L. INTEGRATED DELIVERY SYSTEMS AND JOINT VENTURE DISSOLUTIONS UPDATE

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1. Introduction

This article updates the 1994 CPE article on integrated delivery systems ("IDS"s). Part 1 discusses entities that form a partially integrated delivery system. Part 2 focuses on financial valuations of medical practices acquired by IDSs. Part 3 discusses partnerships between exempt hospitals and physicians, focusing on valuation issues in connection with recent letter ruling requests from hospital-partners.

2. Integrated Health Care Structures

A. Background

Recent years have brought major changes in the way health care is provided. Hospitals are rapidly expanding their capacity to provide outpatient services by creating alliances with individual physicians and medical groups. The forms of alliances vary, but they are generally referred to as "integrated delivery systems," because they bring together, or "integrate," the components that provide health care into one "full-service" health care delivery system. The Service's task is to determine if the new systems operate in a manner consistent with the concept of charity as used in IRC 501(c)(3).

Integration is an evolutionary process. It may start with the creation of a simple physician-hospital organization ("PHO") that arranges with managed care payers (for example, insurance companies or employers) to provide physician or hospital care. Alternatively, a medical group or individual physicians with hospital staff privileges may ask the hospital to provide services, such as billing, collection, and management services, for their private practices. In this case, the hospital takes on the characteristics of a management service organization ("MSO"). A MSO can assume one of several forms and provide a variety of functions. MSO functions may be performed solely by the hospital or an affiliate, or the hospital and physicians may jointly incorporate a separate MSO. The MSO may then purchase the physicians' private practices' tangible assets and provide all management services and nonprofessional staffing for the physicians' private

practices.

Each step in the integration process affects the tax exempt status or tax liability of the components. This section discusses PHOs, MSOs, and their requirements for recognition of exemption under IRC 501(c)(3), as well as the effect on the exempt status or unrelated business income tax liability of hospitals that affiliate with a PHO or MSO.

B. PHOs

A PHO is essentially an independent practice association ("IPA") with a hospital participant. A typical PHO is formed as a nonprofit membership organization controlled equally by an IRC 501(c)(3) hospital ("Hospital") and a medical group, an individual practice association ("IPA"), or individual physicians who practice at or are affiliated with the Hospital. The PHO provides no health care services; its primary functions are to plan and implement a coordinated, cost-effective health-care delivery system that assures all needed medical treatments and resources are available and avoids duplication of services. The PHO contracts with payers on behalf of the Hospital and physicians for the provision of health care services in the community. The PHO, in effect, serves as a joint marketing arrangement for the Hospital and physicians.

(1) Availability of Exemption Under IRC 501(c)(3) for PHOs

A PHO is not a health care provider, as it does not engage in the practice of medicine or operate a hospital. Its negotiates managed care contracts on behalf of its members, the hospital and practicing physicians. It is essentially an IPA with a hospital member. An IPA is not exempt because its primary beneficiaries are its member-physicians rather than the community as a whole. See Rev. Rul. 86-98, 1986-2 C.B. 74. Similarly, a PHO's activities substantially serve the private interests of its member physicians. The member-physicians are "private individuals" subject to the private benefit proscription (and may be "insiders" subject to the inurement proscription). This substantial private benefit would preclude exemption under IRC 501(c)(3). The participation of a hospital in a PHO does not change the outcome. If control is shared with the physicians, the benefit to the hospital is incidental to the private benefit to the physicians.

Even if a PHO is a subsidiary controlled by the exempt hospital, it would not qualify under IRC 501(c)(3). It would not meet the integral part test because of the requirement that the integral part provide services that are essential to the

exempt parent. Although the PHO provides services that benefit the hospital, negotiating managed care contracts for the member-physicians, a substantial if not primary activity, is not an essential service to a hospital.

(2) Ruling Requests By Hospitals to Participate in PHOs

The Service is also receiving ruling requests from hospitals that wish to participate in PHOs either as a member of a separately incorporated PHO, or as a general or limited partner in a PHO partnership or joint venture. The hospitals want to know if their participation in a PHO will jeopardize their exempt status.

In a typical example, a hospital's ruling request states that NP Health Care Organization, Inc. ("NP") is formed as a non-profit membership organization. NP is controlled equally by the Hospital and 275 physicians of the Hospital's 300 person medical staff ("NP Physicians"). The ruling request states that NP provides no health care services. Its sole function is to contract with payers for the provision of health care services to their covered individuals. The ruling request further states that NP in effect serves as a joint marketing arrangement, the expenses of which are intended to be paid by the Hospital member and the NP Physician members in proportion to the benefit derived by each. NP is capitalized equally between the Hospital and NP Physicians.

a. Can the Hospital Participate In A PHO?

Whether a hospital's participation in a PHO jeopardizes its exempt status under IRC 501(c)(3) is determined by the Service's requirements for investments and joint ventures. See Update on Partnerships and Joint Ventures, Exempt Organizations Continuing Professional Education Technical Instruction Program for FY 1993. Exemption will be jeopardized if the PHO is a vehicle for the hospital to share its net income with the medical staff. This would occur if the hospital's control or profit share in the PHO is smaller than its share of the capital contribution, as the member physicians would receive benefits disproportionately greater than their risk. To be consistent with exempt status under IRC 501(c)(3), the expenses of the arrangement should be paid by the hospital and the aggregate physician members in proportion to the benefit derived by each to assure that only incidental private benefit is conferred on the physician members, who otherwise would have no financial risk.

Another situation in which a PHO could jeopardize the exempt status of a participating hospital is where the PHO is a vehicle for sharing capitated payments

with the physicians and the physicians are being paid more than reasonable compensation for their services or the hospital otherwise receives less than a fair portion of income. This situation would result in inurement or private benefit depending on whether any participating physicians are insiders of the hospital subject to the inurement prohibition.

b. Factors to Consider

G.C.M. 39732 (May 19, 1988) describes factors that the Service will scrutinize when an exempt organization is involved in a partnership with physicians. These factors are also useful in determining if a hospital's participation in a PHO adversely affects its exempt status. The factors are:

1. Is there a disproportionate allocation of profit or loss in favor of the for-profit partner?

2. Is there a nominal or insufficient capital contribution by the for-profit partner?

3. Are new equipment or services brought into the partnership or is the service or equipment already available in the area?

4. Is existing hospital equipment or facilities sold or leased to the partnership?

5. Is any service being provided by the hospital at less than fair market value?

6. Does a for-profit limited partner have significant influence and control over operations?

7. Does the exempt organization bear all risk or liability for the partnership losses?

8. Are commercially unreasonable loans made to the partnership (low interest or inadequate security)?

C. MSOs

A typical MSO acquires tangible medical practice assets from participating

physicians and provides those assets as well as administrative and managerial services to private medical practices in return for a portion of practice revenues. A MSO does not provide medical care in an integrated system, as the physicians who sold the assets retain ownership of their clinical practices and medical records. A hospital's involvement in a MSO can vary. The MSO can be a separate activity within the hospital, though it is typically a separate joint venture, partnership, or corporation in which the hospital, either directly or through a subsidiary, is a participant, partner, or shareholder.

The composition of the MSO's board of directors can vary, and may or may not include representatives of the hospital. The MSO's management services agreement ("MSA") normally establishes a for-profit physician group ("Physician Group") to represent the member medical group(s) or individual physicians who join the MSO.

The scope of the MSO's operations will often include the following:

> Contracts stating the terms of the management, billing, collection, purchasing, leasing and personnel services provided by Subsidiary to Physician Group as well as the charges for these services; an exclusivity agreement that Physician Group will use only the MSO; a description of medical services, specifying sites, hours of operation, and similar matters; Physician Group's obligation to furnish physicians in sufficient number and geographical distributions to provide services; individual physician performance standards; description of the extent of services provided by the MSO to Physician Group, which include an obligation to provide fully equipped and staffed practice sites, financial services including billing in the name of Physician Group (using the medical group or physician provider number), and collection and accounting for all program revenues of individual medical group(s) and physicians comprising Physician Group; payment to Physician Group of aggregate compensation determined in accordance with budgeting provisions of MSA and MSO performance standards; and compensation methodology.

A MSO generally will not qualify for exemption under IRC 501(c)(3) because it is unlikely to have a charitable purpose. In addition, a MSO, similar to the PHO discussed above, serves the private interests of participating physicians in more than an insubstantial degree. However, ruling requests may be submitted to

the Service by exempt entities (e.g., hospitals) that plan to participate in a MSO arrangement as an initial step toward integration with certain physicians and/or medical groups regarding the effect of such participation on their exempt status.

D. Can a Tax Exempt Hospital Participate In a MSO?

As with the PHO, whether a tax exempt hospital's participation in a MSO will jeopardize its exempt status is determined by the Service's requirements regarding investments in partnerships and joint ventures. This applies regardless of the particular form of participation. The MSO must be a reasonable investment for the hospital. The expenses of the arrangement should be paid by hospital and the aggregate physician members in proportion to the benefit derived by each to assure only incidental private benefit is conferred on the physician members, who otherwise would have no financial risk. If the hospital's control and financial share of the MSO is disproportionately less than its capital contribution, the arrangement may jeopardize the hospital's exempt status because of private benefit (or inurement, in the case of insiders) to participating physicians.

The MSO's purchase of physicians' assets raises an additional significant concern. Anytime there is a purchase of assets by an exempt organization from related parties or insiders, fair market value ("FMV") becomes an issue. If greater than FMV is paid, there are significant private benefit and inurement issues.

E. Unrelated Business Income Tax ("UBIT") Considerations For Hospitals in PHO and MSO Arrangements

A hospital that participates in a PHO or MSO through a partnership or joint venture, or operates a MSO as an unincorporated activity, will generally be subject to unrelated business income tax on income it derives from the arrangement. Except for rare and unusual circumstances, the income of a separately incorporated PHO or MSO will be taxable at the corporate level and will not be attributable to the hospital.

IRC 511(a)(1) imposes a tax on the unrelated business taxable income of organizations described in IRC 501(c). An IRC 501(c)(3) hospital is subject to UBIT.

IRC 513(a) provides that the term "unrelated trade or business" means, in the case of any organization subject to the tax imposed by IRC 511, any trade or business which is not substantially related to the exercise or performance by such

organization of its charitable, educational or other purpose or function constituting the basis for its exemption under IRC 501.

Reg. 1.513-1(a) provides that gross income of an exempt organization subject to the tax imposed under IRC 511 is includible in the computation of unrelated business taxable income if (1) it is income from trade or business, (2) such trade or business is regularly carried on by the organization, and (3) the conduct of such trade or business is not substantially related (other than through the production of funds) to the organization's performance of its exempt function.

Reg. 1.513-1(b) provides that the term "trade or business" has the same meaning for purposes of IRC 513 as it has for taxable corporations under IRC 162. It generally includes any activity carried on for the production of income from the sale of goods or performance of services. The regulations further state that an activity of producing or distributing goods or performing services from which a particular amount of gross income is derived does not lose its identity as a trade or business merely because it is carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which may, or may not, be related to the exempt purposes of the organization. The regulations provide an example: the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital and patients of the hospital in accordance with its exempt purposes.

A hospital's receipt of revenues from MSO services would be UBI because these services do not serve charitable purposes, are provided to non-patients of hospital and entities outside of hospital's exempt affiliated system, and are regularly carried on. The example in the Reg. 1.513-1(b) is applicable to income derived from a PHO. Similar to the pharmaceutical sales to hospital patients in the example, income from PHO services performed for the benefit of hospital and its patients would normally be considered related and would not be subject to UBIT. However, PHO services provided to patients in the member physicians' private practices do not serve the hospital's exempt purposes and generate unrelated business income. This "relationship" principle is illustrated in hospital pharmacy sales to patients (Rev. Rul.s 68-374, 375 and 376, 1968-2 C.B. 242, 245 and 246) and the sale of plasma by an exempt blood bank (Rev. Rul. 78-145, 1978-1 C.B. 169).

3. <u>IDS Issues</u>

This section discusses issues emerging from IDS practices in recruiting and compensating physicians, and in appraising or valuing medical practices that an IDS intends to purchase.

These issues may arise in either an application from a newly created IDS or component, or an examination of an existing organization.

A. Physician Recruitment

Generally, an IDS offers "managed care," which is a method for controlling costs by reducing unnecessary procedures. Managed care places a premium on the services of primary care physicians, who act as the "gate keepers" of a managed care system. A primary care physician's ability to assess patient needs and identify when a patient needs specialist services is one key to managed care. The shift to managed care has created a demand for general practitioners, who perform primary care. To meet the demand, IDSs usually offer incentives to physicians they hope to recruit. The Service's task is to determine if recruiting incentives are justified in terms of the community benefit that results from the physician's association with the IDS. We accomplish this task by evaluating the terms and conditions under which new physicians are recruited as well as determining if the physician receives an amount in excess of reasonable compensation.

B. Reasonable Physician Compensation

Whether recruiting incentives are reasonable depends on whether the total compensation of the physician is reasonable, both in the way it is determined and the actual amount. The reasonableness of compensation is judged under a facts and circumstances test, and is determined case-by-case. Rev. Rul. 69-383, 1969-2 C.B. 113, lists some of the factors the Service examines in testing whether a compensation plan results in prohibited inurement. A compensation plan of an exempt organization does not result in prohibited inurement if: (1) the compensation plan is not inconsistent with exempt status, such as, merely a device to distribute profits to principals or transform the organization's principal activity into a joint venture; (2) the compensation plan is the result of arm's-length bargaining; and (3) the compensation plan results in reasonable compensation. To be reasonable in amount, compensation should be comparable to payment arrangements adopted by other medical groups of similar size and composition in the same geographic area.

(1) Factors to Consider

A major factor in determining the reasonableness of compensation is the independence of the board of directors that determine the compensation. How many financially interested individuals serve on the board? Do financially interested board members refrain from voting on physician compensation? Generally, if a board contains no financially interested members or financially interested members refrain from voting, there is a greater presumption that compensation is reasonable. Conversely, if financially interested individuals serve on the board, further investigation is warranted. For example, if an IDS employs 32 physicians from three different medical groups, and Medical Group 1 is the only Medical Group represented on the board, reasonableness of compensation would be suspect, especially if Medical Group 1 physicians received disproportionately higher compensation than the other physicians in the same specialty with the same experience and training.

A second factor to consider is comparability to the compensation levels of physicians in similar specialties. This determination is easier in urban areas, where there are many similarly situated physicians, and where there are likely to be regional studies of physician compensation. However, even in small communities, where there may be no other physicians in similar specialties providing services or no reliable regional studies indicating ranges of physician compensation, there is data that can be consulted. For example, the American Hospital Association produces an annual survey of average physician compensation for given specialties. In addition, the 1993 Hay Hospital Compensation Survey, sponsored by the Hay Group and the American Society for Healthcare Human Resources Administration, contains information on compensation practices of 1,256 hospitals. Another available comparison is data showing the range of salaries for like specialties in the same state, which can be compared with data from communities similar in size and socio-economic demographics to the IDS in question. Such data could also be supplied by state and local medical societies, and national trade associations for physicians.

Another factor that is helpful in determining reasonableness is written evidence of arm's-length salary negotiations between the physicians and the organization. This may be in the form of formal offers that passed between the parties or contemporaneous memoranda that document face-to-face negotiations. Proof of valid job offers that the organization's physicians received from other institutions would also be helpful in establishing that negotiations were arm's-length and that compensation is comparable to that paid by similar institutions.

C. Financial Valuations of Medical Practices

Valuation of assets or medical practices is a key issue in many cases involving health care organizations, whether they be applications for recognition of exemption, requests for private letter rulings, or examinations. Whether the valuation placed on an asset represents fair market value (FMV) depends on the quality of the appraisal. This section provides information to help determine whether an appraisal accurately reflects FMV. It also raises areas of concern with respect to appraisal methods used in the acquisition of hospitals, medical practices and partnerships. FMV is defined as the price at which a willing buyer and a willing seller would agree, neither being under any compulsion to buy or sell, and both having a reasonable knowledge of the relevant facts. Rev. Rul. 59-60, 1959-1 C.B. 237.

(1) Background

The Service includes the following language in all favorable IRC 501(c)(3) IDS exemption letters:

Applicant represents that all assets acquired will be at or below fair market value ("FMV") and will be the result of independent appraisals and arm's-length negotiations.

Applicant's representations must include an appraisal which details the market price of the asset(s). Appraisals are pivotal in determining if a price represents FMV, and whether Applicant establishing an IDS by purchasing a practice may receive exemption. Thus, a critical issue is whether the appraisal is correctly performed, especially where insiders participate in the transaction.

National Office Appeals, Office of Appraisal Services, ("CC:AP:AS"), in reviewing valuations submitted in IDS cases at the request of the Exempt Organizations Technical Division, has stated generally that FMV is determined within the framework of the business enterprise's value to the most likely hypothetical purchaser. In this situation, the hypothetical purchaser usually is assumed to be a commercial health care corporation. The business enterprise value ("BEV") is defined as the total value of the assembled assets that comprise the entity as a going concern (the value of a company's capital structure). BEV can be defined in other ways. Another definition of a more technical nature states it is the capital structure of the business, the components of which are common (or

partner's) equity, preferred equity (stockholders), and long term debt. By removing long term debt from the business enterprise, you obtain shareholders' (or partners') equity, or the net worth of the firm. The BEV is the basis for most appraisals submitted to the Service.

(2) How Is BEV Determined?

CC:AP:AS requested in all IDS applications that the valuation provide all recognized approaches for estimating BEV, including the income approach, market approach, and cost approach. The income approach often is the most relevant, as it includes the "excess earnings method" described in Rev. Rul. 68-609, 1968-2 C.B. 327, and was approved for the valuation of intangible assets in Rev. Rul. 76-91, 1976-1, C.B. 149. In many valuations of medical groups, the seller places a substantial value on intangible assets. Intangibles are difficult to measure in terms of real value and often are a likely place to inflate the valuation.

a. Income Approach

The first approach to estimating BEV, the income approach, focuses on incorporating the specific operating characteristics of the seller's business into a cash flow analysis. The discounted cash flow ("DCF") method will be employed in this discussion. The DCF represents one method often used in the income approach to valuation. In the analysis, cash flow that could potentially be taken out of the company without impairing operations and profitability is estimated. The cash flow available for distribution is then discounted to present value at the indicated discount rate[1] and totaled.

The DCF method of estimating economic value is based on the fact that a sum of money expected to be received some time in the future has a lower present value than the same amount of money in hand today. Thus, a valuation will project the cash flows of a business for some future time period to determine present

[1] The discount rate is determined by an assessment of the level of risk of a particular enterprise. It is based on an industry rate of return. The discount rate is broken down into a mathematical period factor (.9129, .7607, etc.) for each of the years in which cash flow projections are made. The various factors are then multiplied by each year's projected cash flow and all of the annual cash flows are added together to arrive at a present value. See Exhibit B, line 15 entitled "Present Value Factor @ 16% Discount Rate" for an understanding of how the period factor affects the value of the cash flows.

value. This future time period, often five years with medical groups, is referred to as the estimation period. The sum of the present yearly value of cash flow available for distribution is added to the terminal value or reversion (the selling price of the company at the end of the estimation period) to arrive at the indicated BEV. See James H. Zukin, Financial Valuation: Businesses and Business Interest, pp. 16-18 (1992).

The term "income" does not refer solely to income in the accounting sense. Income includes not only cash flow earned from the assets but also such future benefits as synergy, growth or expansion. See Valuation - A Researcher's Guide, Sept. 1992. Look at what the company is worth today and tomorrow in terms of earnings, and add or subtract from this amount the value of its competitive position and its future growth to determine its worth in five years. This future value must be discounted to arrive at today's present value (FMV).

The key to understanding the income approach is to recognize that the value of an asset or business is equal to the present worth of the future benefits of ownership. In other words, an organization purchasing a medical practice must ascertain if today's sales price is equal to its future earnings. To explain the income approach in a more technical manner involves a number of steps.

The first step is to develop financial statements for the estimation period. This data is usually derived using historical information from prior fiscal reporting periods. The historical information should then be adjusted or "normalized" for any extraordinary occurrences during the estimation period or for known changes in revenues or expenses which will be sustained into the future. The resulting financial statements are called the "normalized financial statements." After the normalized financial statements are developed, reasonable assumptions are made regarding rates of revenue increase, patient volume, and rates of expense increase based upon current market conditions, growth, and best estimates of inflation trends. In all cases, reasonable assumptions with respect to the rate of revenue increases and patient volume combined with common inflationary increases should be employed.

After a reasonable level of revenue and expense is calculated, earnings before depreciation, interest, and taxes ("EBDIT") are calculated. EBDIT is then adjusted for changes in depreciation, changes in net working capital, changes in capital expenditures and new capital.

The formula can be expressed as follows:

EBDIT
+ Depreciation and Amortization
+/- Changes in Net Working Capital
+/- Changes in Fixed Assets
+/- Changes in Capitalization
Earnings Before Taxes ("EBT")

The next step is to determine earnings after taxes, using the applicable tax rates. This will be discussed more fully later in this article. The number remaining after the adjustment for taxes represents "debt free cash flow available for distribution." This number will be multiplied by the discount rate factor to determine the unadjusted BEV.

b. Market Approach

The second method of estimating BEV, the market approach, measures value based on the purchase price paid in the market place for similar assets. This approach is familiar to most home purchasers--comparing the value of one home with other similar homes to determine FMV. Obviously, with the sale of a business it is more difficult to find comparable entities; therefore, actual purchase price multiples paid for similar companies are evaluated, adjusted and applied to the operating data of the seller's business to arrive at FMV. Factors affecting comparability can include geographic markets served, competitive position, profitability, growth prospects, risk perceptions, and financial composition (i.e., capital structure).

c. Cost Approach

The last method of estimating BEV, the cost approach, measures value by determining the cost to replace or reproduce an asset, less an allowance for physical deterioration or obsolescence. The cost approach uses the FMV of the individual corporate assets as a starting point. After the FMV of all assets has been estimated, the book value of liabilities is subtracted to arrive at an indication of the cost of the business. The "adjusted net asset" method of determining cost takes into consideration the potential for monetary and tangible asset value greater than the enterprise value. Intangible assets, if any, are typically not valued under this method unless their value can be estimated reasonably.

d. Summary of Approaches

CC:AP:AS expects all three methods of estimating BEV to be included in an appraisal. CC:AP:AS cautions, however, that even in those cases where the DCF method is appropriate to value the business being sold, the valuation must be based on a discount rate supportable by market transactions. To ensure a correct valuation, the results of the income approach should be tested against other approaches such as market and cost.

(3) Areas of Service Concern

a. Annual Revenue Growth Rate

In at least one IDS case, CC:AP:AS requested that an IDS applicant revise its valuation of the medical group being purchased. The reason for requesting the revision was that the various income, debt and equity ratios provided by the applicant's appraisal indicated a financially weak medical group.

CC:AP:AS is requested revision highlighted areas where an appraisal could produce an artificially high value, resulting in the medical group receiving more than FMV. The first revision sought was the incorporation of a lower average annual revenue growth rate than assumed in the original valuation. A high average annual revenue growth rate produces a higher valuation of assets while a lower revenue growth rate reduces future cash flows, which correspondingly reduces the net worth (the purchase price) of the business. The result of the revision was to lower the seller's average annual revenue growth rate and, therefore, to reduce the purchase price of the medical group.

The Service requires that appraisals include reliable projections of annual revenue growth rates in the geographic location of the applicant. These figures should then be correctly projected into the annual revenues of the seller's business during the estimation period. For a discussion of methodologies employed in determining growth rate, see James R. Eck, Asset Valuation, p. 290 (1991).

b. After-Tax Cash Flows

CC:AP:AS has also required an applicant to revise its income approach valuation (DCF method) to an after-tax rather than pre-tax cash flow assumption. This adjustment resulted in a significantly lower BEV than originally submitted. Because of this important adjustment, the Service received a substantially more accurate valuation analysis, reducing the private benefit or inurement possibilities

inherent in the transaction.

Appraisals are sometimes based on the purchaser's tax status. If the purchaser is a for-profit organization the appraisal will be based on an after-tax cash flow analysis, thus reducing the purchase price by the amount of the tax. If the purchaser is tax exempt, the monetary impact of federal and state taxes will not be included in the appraisal. But, the Service's position is that a pre-tax cash flow valuation improperly increases the appraised value by the amount of the unpaid tax. See Louis Bersenson v. Commissioner, 59 T.C. 412, 421 (1972). After all, FMV is based on the business enterprise's value to the most likely hypothetical purchaser, assumed to be a commercial health care corporation that would have to pay taxes. If the value of the tax is not adjusted out of the purchase price (present value of future cash flows) the seller receives an inflated price compared to the sale of the same asset(s) to a for-profit purchaser.

Because of the higher appraisal resulting from the pre-tax cash flow analysis, a for-profit seller may attempt to have this approach employed to calculate the value of assets. The pre-tax cash flow method of appraisal, in the sale by a for-profit entity to a non-profit entity, automatically creates an inflated value to the seller. A for-profit entity may attempt to realize a greater profit by selling its assets to an exempt organization versus selling the same assets to a for-profit business.

To demonstrate the amount of money involved, review the first three attached exhibits. Exhibit C demonstrates the effect on the appraisal when a pre-tax cash flow analysis is employed. In the lower left corner, the indicated BEV is stated at $19,800,000. This is an example of an incorrect cash flow analysis which creates an inflated price for the seller. In Exhibit A the cash flow analysis is revised, but it only incorporates a partially correct after-tax cash flow analysis. The indicated BEV is stated at $16,500,000, a $3,300,000 or 18% difference in value. This is a substantial difference even though it is not consistently calculated. In contrast, Exhibit B shows an after-tax cash flow analysis using an after-tax cash analysis for the terminal year or reversion (i.e., the value of the business after the estimation period). In the lower left hand corner the indicated BEV, using a consistently applied after-tax income rate, is stated at $11,066,000 or 44% less than the original valuation submitted by Applicant, a very substantial difference. The Service expects an after-tax cash flow analysis which is consistently calculated as illustrated in Exhibit B.

c. The Discount Rate

The discount rate should reflect state and federal income taxes. "The discount rate must exactly match the benefit stream to be valued. This means that discount rates that are derived from information based on after-tax income must not be applied to anything other than after-tax income of the subject company..." See West Jones, Handbook of Business Valuation, p. 208 (1990). Also, the lower the discount rate, the higher the current value (which will be used as a basis for the sales price). See Handbook of Business Valuation, supra, p. 248; which shows a cash flow analysis for a 10 year period. The same forecast is discounted at a rate of 10% and at 20%. Notice how the present value of the business is reduced by the higher discount rate.

(4) Tax Exemption Considerations

IRC 501(c)(3) describes organizations organized and operated exclusively for charitable purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual. Although IRC 501(c)(3) does not expressly address hospitals or health care providers, Rev. Rul. 69-545, 1969-2 C.B. 117, establishes the "community benefit standard," which focuses on factors indicating that the operation of a hospital benefits the community rather than serving private interests. The facts in Situation 1 of the revenue ruling state that the hospital is controlled by a board composed of independent civic leaders, has an open medical staff, an active, open, and accessible emergency room serving everyone without regard to ability to pay, and treats all patients able to pay for their care, including Medicare and Medicaid patients. Therefore, the hospital operates to serve public rather than private interests. In Situation 2 of the revenue ruling, five doctors who owned a for-profit hospital sold their interest in the hospital for fair market value to a nonprofit hospital that they controlled and that generally served only patients of those physicians. The new nonprofit hospital was not exempt because of excessive private benefit to the five doctors even though it paid FMV for the hospital.

a. Private Benefit

An organization cannot be organized or operated exclusively for charitable purposes unless it serves a public rather than a private interest. Thus, to meet the requirements of IRC 501(c)(3), an organization must establish that it is not organized or operated for the benefit of private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests. See Reg.

. 1.501(c)(3)-1(d)(1)(ii). The private shareholders or individuals are defined as persons having a personal and private interest in the activities of the organization. See Reg.. 1.501(a)-1(c).

The private benefit prohibition of IRC 501(c)(3) applies to all kinds of persons and groups, not just to those "insiders" subject to the more strict inurement proscription. The private benefit prohibition applies to all the physicians in a medical group that sells its assets to a tax exempt organization and all physicians subsequently performing services for the organization. Benefits to the physicians must be balanced against benefits to the public.

The organization may provide benefits to "private individuals," or persons who are not members of a charitable class, provided those benefits are "incidental" both quantitatively and qualitatively. See G.C.M. 37789 (Dec. 18, 1978). To be qualitatively incidental, private benefit must be a necessary concomitant of an activity that benefits the public at large; in other words, the benefit to the public cannot be achieved without necessarily benefitting certain private individuals. Id. at 6. In this situation, the community can receive the same services, without unnecessarily benefiting the seller, if an after-tax cash flow analysis is employed by the organization. Thus, if a pre-tax cash flow analysis is employed, the private benefit to the medical group, derived from the inflated sale of assets, may well be substantial.

To be "quantitatively incidental," any private benefit must be insubstantial "measured in the context of the overall public benefit conferred by the activity." G.C.M. 37789 at 8. Whether private benefit is quantitatively incidental or insubstantial depends on the reason behind the benefit and whether the benefits provided are greater than necessary to accomplish the exempt purpose. As the reason for using a pre-tax cash flow analysis is to further private interests through payment of more than FMV rather than charity, and because it provides benefits to the private interests greater than necessary to accomplish exempt purposes, the private benefit from use of the pre-tax analysis would be considered quantitatively substantial as measured in the context of the overall public benefit to the community. This overpayment would also be a serious negative fact in making a determination of an organization's community benefit. See Rev. Rul. 69-545, supra. Accordingly, an organization that bases the purchase price of assets from a financially interested party on an appraisal using a pre-tax cash flow analysis, thus paying considerably more than FMV, could be precluded from exemption under IRC 501(c)(3) because of substantial private benefit. See Rev. Rul. 69-266, 1969-1 C.B. 151.

It is important to remember that private benefit can involve anyone, including an unrelated seller of assets to an exempt organization. In American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989), the Tax Court ruled the private benefit prohibition includes unrelated third parties. An organization's conferral of benefits on disinterested persons can cause it to serve a private interest within the meaning of Reg. 1.501(c)(3)-1(d)(1)(ii). Id. at 1069.

Prohibited private benefit may include an "advantage; profit; fruit; privilege; gain or interest." Retired Teachers Legal Defense Fund v. Commissioner, 78 T.C. 280, 286 (1982). It is clear that the medical group and individual physicians receive an advantage, profit, fruit, privilege, gain, or interest as a natural result of the sale of their practice as well as from their subsequent provision of professional services to the IDS. It is also clear that an unrelated business or individual may receive an advantage, profit, fruit, privilege, gain, or interest in the sale of assets to an exempt organization if the valuation is based on a pre-tax cash flow analysis. The advantage or profit to the unrelated third party is directly proportional to the increased value of the asset as a result of the elimination of taxes from present and future cash flows. As stated previously, a tax exempt organization may not provide benefits to third party unrelated individuals or persons who are not members of a charitable class if those benefits are not "incidental" both quantitatively and qualitatively. See G.C.M. 37789, supra.

b. Private Inurement

Private inurement generally involves persons who, because of their particular relationship with an organization, have an opportunity to control or influence its activities. These individuals generally are referred to as "insiders." See American Campaign Academy v. Commissioner, supra.

Private inurement is narrower than the concept of private benefit. Both may be present on a given set of facts. The Tax Court addressed the distinction in American Campaign Academy, supra, stating that "while the prohibitions against private benefit and private inurement share common and overlapping elements, the two are distinct requirements which must independently be satisfied." Inurement generally will not be found in the absence of an insider, while private benefit can involve anyone. However, while a certain amount of private benefit is allowable if it is incidental to accomplishment of exempt purposes, IRC 501(c)(3) contains a strict prohibition of inurement. Therefore, an important issue is whether a physician is an insider.

In G.C.M. 39670 (June 17, 1987), the Office of Chief Counsel stated that all persons performing services for an organization have a personal and private interest in it and may possess the requisite relationship to find private inurement. The Service's position recognizes the fact that certain key employees of an exempt organization have the potential to exert inside influence. It follows that physicians in a medical group providing services for an IDS, either as employees or under a contract, may enjoy considerable influence over the organization. This insider status would require the Service to examine the potential for inurement as well as substantial private benefit.

Inurement will not be present if an organization can demonstrate all its relationships with potential "insider" physicians are truly at arm's-length and the physician has no chance to employ inside influence. Even if physicians are subject to the inurement proscription, that does not mean there can be no economic dealings between them and the organization. The inurement proscription does not prevent the payment of reasonable compensation for goods and services or for the purchase of assets at FMV. It is aimed at preventing dividend-like distributions of charitable assets or expenditures to benefit a private interest. See G.C.M. 39862, supra.

However, a classic example of inurement is the purchase at more than FMV by an exempt organization of assets owned by a financially related party. In this situation, the physician's insider status with the applicant would create prohibited inurement if the assets conveyed are over-valued.

c. Fraud and Abuse Laws

Hospital administrators and their boards of directors are aware that if they do not align quickly with well-established primary and specialty medical groups, their hospitals may not be positioned to take advantage of the growth in managed care. Hospitals, sensing a threat to their survival, may be tempted to pay a premium price to acquire a medical group. Therefore, medical group assets may intentionally be purchased at a premium through apparent arm's-length negotiations, which in reality employ appraisals designed to disguise a payment for physician referrals to the hospital.

The federal anti-kickback restrictions contained in the Social Security Act, which prohibit the payment of remuneration in return for the referral of Medicare or Medicaid patients, provide in pertinent part:

> Whoever knowingly and willfully solicits or receives (or offers or pays) any remuneration (including any kickbacks, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind --
>
> (A) in return for referring an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under [the Medicare program] or a State health care program, or
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under [the Medicare program] or a State health care program, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both. 42 U.S.C. section 1320a-7b(b)(1) and (2).

In addition to the monetary fine and imprisonment, individuals or entities convicted of a violation of the federal anti-kickback statute face mandatory exclusion from participation in the governmental payment programs. 42 U.S.C. section l320a-7(a). Moreover, the Secretary of the Department of Health and Human Services ("HHS") may exclude any person from participation in the Medicare or Medicaid programs if the Secretary administratively determines that such person committed an act described in the anti-kickback statute. 42 U.S.C. section 1320a-7(b)(7). Exercise of the Secretary's discretionary authority may result in program exclusion regardless of whether a person is convicted of a criminal violation.

The scope of activities prohibited by the federal anti-kickback statute is broad. Clearly, it applies to a direct cash payment made in return for a referral. The courts also have found the statute to apply in situations where the receipt of consideration, directly or indirectly, induces a referral. U.S. v. Bay State Ambulance and Hospital Rental Service, Inc., 874 F.2d 20 (1st Cir. 1989); U.S. v. Kats, 871 F.2d 105 (9th Cir. 1989); U.S. v. Greber, 760 F.2d 68 (3rd Cir. 1984), cert. denied, 474 U.S. 968 (1985). Read literally, however, it is also possible for the rule to apply to activities that are common practice and may not have been intended to be prohibited by Congress.

Recognizing this lack of clarity, as a part of the Medicare and Medicaid Patient and Program Protection Act of 1987, Congress instructed the Secretary of HHS to issue regulations specifying certain "safe harbors," consisting of those payment practices that will not be subject to criminal prosecution under the federal statute and will not provide a basis for exclusion from participation in the Medicare and Medicaid programs under the Secretary's discretionary authority. In response to the congressional directive, the Office of the Inspector General ("OIG") of HHS published regulations outlining certain safe harbors under the federal anti-kickback statute (the "Regulations"), 56 Fed. Reg. 35952 (1991).

The Regulations contain a safe harbor provision for remuneration paid in connection with the sale of a physician's practice. The preamble to the Regulations acknowledges that hospitals and other health care organizations often acquire physician practices in order to ensure a stream of referrals and pay more money for the practice than would otherwise be available in the market place. In these circumstances, the additional compensation reflects the value of the referrals and constitutes an illegal payment. As a result of this abuse, the safe harbor provision contained in the regulations relates only to sales of practices between practitioners where the selling practitioner will not be in a position to make referrals to the purchasing practitioner after one year from the date of the sale. 56 Fed. Reg. 35985 (1991) (to be codified as 42 C.F.R. section 1001.952(e)).

A 1992 letter from the OIG of HHS to the Technical Assistant (Health Care Industries) (copy attached at Exhibit D) expresses concern that some acquisitions of assets from medical groups may violate the Medicare and Medicaid anti-kickback statute, 42 U.S.C. 1320a-7b(b). If a significant acquisition is illegal, the organization may jeopardize its exemption under IRC 501(c)(3) by having a substantial nonexempt purpose. At issue are intangible assets that relate to continuing treatment of the selling practice's patients. The OIG letter describes as "suspect" amounts paid that exceed the FMV of tangible assets, i.e., amounts paid for goodwill, value of an ongoing business, covenants not to compete, exclusive dealing arrangements, patients lists, or patient records. Where the courts or the OIG have not definitively determined the illegality of particular remuneration, the Service generally will not deny or revoke exemption. However, the Service must be aware of this potential problem. The Service currently includes the following language in favorable exemption determination letters:

This ruling is conditioned upon your not violating the federal anti-kickback restrictions contained in section 1128(b) of the Social Security Act, 42 U.S.C. 1320a-7b(b)(1) and (2), which prohibit the payment of

remuneration in return for the referral of Medicare or Medicaid patients. We express no opinion as to whether your planned purchase of a private group medical practice or your subsequent payment for physician services complies with these provisions.

4. Partnerships with Hospital Participation

A. Background

During the 1980s, numerous partnerships, joint ventures and for-profit organizations were created to offer various types of specialized outpatient medical services. These providers were generally created through either a direct or indirect partnership between a hospital and physicians.

In a typical scenario, a hospital fears that without its participation in the partnership, the physicians will establish a new service alone or in conjunction with a competing hospital. To avert possible loss of revenues from that venture and to prevent loss of physician loyalty, the hospital becomes a partner. This combined involvement of the hospital and the physicians ensures the physician's loyalty and their subsequent referrals to hospital. See Sullivan and Moore, A Critical Look at Recent Developments in Tax Exempt Hospitals, Journal of Health and Hospital Law (March 1990).

B. Service Position on Exempt Hospitals Participating in Partnerships

As partnerships began to proliferate, the Service received ruling requests from hospital partners for private letter rulings that participation would not jeopardize exempt status. Generally, the Service ruled that the hospital's participation in the partnership would not affect its exempt status if certain requirements were met. The following four G.C.M.s discuss the Service's requirements for an exempt organization to participate in a partnership: G.C.M. 39862 (Nov. 21, 1991) involves the sale of a net revenue stream; G.C.M.s 39005 (June 28, 1983) and 39444 (July 18, 1985) establish requirements for an exempt organization's participation as general partner; and G.C.M. 39732 (Nov 4, 1987) discusses an exempt organization as a partner in a joint venture and states that no showing is required that the charitable goal could not be accomplished but for the participation in the partnership.

C. OBRA 1993

The Omnibus Budget Reconciliation Act of 1993 ("OBRA"), § 13562, 107 Stat. 312 (1993), enacted new restrictions on Medicare and Medicaid reimbursement that are bringing about the divestiture and restructuring of joint ventures and limited partnerships between IRC 501(c)(3) hospitals and physicians. Effective January 1, 1995, providers of certain medical services will not be allowed to bill Medicare and Medicaid for various types of services performed pursuant to referrals by a physician who has a financial relationship with the provider of the services. The affected services are: clinical laboratory; physical therapy; occupational therapy; radiology or other diagnostic services; radiation therapy; durable medical equipment; parenteral and enteral nutrient equipment and supplies; prosthetics, orthotics, and prosthetic devices; outpatient prescription drugs; and inpatient and outpatient hospital services.

There are three reasons for this legislation. First, there is a risk that physician-investors may refer patients to the providers in which they have an interest, rather than the ones that offer the best care. Second, patients may be referred for expensive services that are not necessary and that drive up the cost of Medicare. Lastly, competition is undercut, while hidden payments become a cost of doing business. H.R. Rep. No. 231, 92nd Cong., 1st Sess. 107, reprinted in 1972 U.S. Code Cong. and Ad. News 4989, 5093.

OBRA provides certain exceptions to the ownership and investment prohibition. Section 13562(d)(3) of OBRA provides that a hospital is exempt from its provisions under certain situations. Under the hospital exemption, financially interested physicians can refer patients if: the physician is a hospital employee (13562(e)(2)); the physician provides personal services as a consultant or contractor to the hospital (13562(e)(3)); or the hospital buys the physician's practice (13562(e)(6)).

(1) Ruling Requests by Partner-Hospitals

As a result of OBRA, and the fact that a number of third party insurers have decided to follow federal reimbursement policy, hospital/physician partnerships face a 30 to 70 percent revenue loss. Predictably, the Service has seen a sharp increase in ruling requests involving the divestiture and restructuring of partnerships between hospitals and physicians. Through repurchase of physicians' interests, hospitals seek to prevent large future losses and perhaps the loss of the total investment; ensure continued physician loyalty and referrals; prevent the physician-partner's loss of investment or investment income; and continue to compensate the former physician-partners for providing medical service through

the partnership.

The ruling requests from hospitals and applications for exemption under IRC 501(c)(3) from hospital controlled subsidiaries have involved the following facts:

1. A hospital, which is a limited or general partner in a partnership with physicians, either directly or indirectly with entities controlled by physicians, requests a ruling that its exempt status will not be affected by the FMV purchase of the physicians' shares in the partnership;

2. A newly incorporated subsidiary of a hospital requests recognition of exemption to take over the operation of a partnership through the purchase at FMV of the physicians' shares in the partnership; and

3. A hospital's controlled for-profit subsidiary is purchasing the physicians' shares in a partnership in which the subsidiary is a partner, and the hospital requests a ruling that its involvement with the partnership through its for-profit subsidiary will not affect exempt status.

In each situation, a FMV sales transaction is a key factor in determining whether there is inurement or excessive private benefit. Because a BEV approach to FMV will be employed to evaluate the partnership, an important consideration is whether the income, market, or cost approach is the most appropriate method of valuation. All valuations submitted in connection with a partnership ruling request should provide all recognized approaches for estimating BEV, including the income, market, and cost approaches.

An appraisal omitting the impact of OBRA automatically creates an inflated sales price for physician-partners because it uses incorrect projections. The difference between FMV and a price arrived at by the omission of OBRA-created reductions in revenue (the "premium") is a payment for an intangible asset which may represent the disguised purchase of physician referrals.

Inurement or private benefit may occur in the sale of the physicians' portion of the Partnership when the appraisal of the partnership uses a cash flow analysis which omits the impact of OBRA. A cash flow analysis that fails to reduce gross

receipts may be employed strictly for the private benefit of the physician-partners to derive a quantitatively and substantially inflated purchase price. The hospital's acceptance of a cash flow analysis resulting in the payment of more than FMV to a financially interested party is contrary to charitable purposes, and would be considered quantitatively substantial as measured in the context of the overall public benefit to the community. See G.C.M. 37789, supra and Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968).

A classic example of inurement is the purchase at more than FMV by an exempt organization of assets owned by a financially related party. In this situation, the physician-partner's insider position in connection with the Hospital and the inflated valuation of the partnership shares would likely result in prohibited inurement. In conclusion, prohibited inurement may result because the hospital pays more than FMV for the physician's shares of the partnership when it employs a cash flow analysis omitting the impact of OBRA.

D. Valuation Issues in Partnerships

(1) Pre-IDS Approaches to BEV

The cost approach, which measures FMV by determining the cost to replace or reproduce an asset, less an allowance for physical deterioration or obsolescence, was previously employed by hospitals repurchasing another partner's partnership shares. The cost approach utilizes the FMV of the individual corporate assets as a starting point. After the FMV of all assets has been estimated, the book value of liabilities is subtracted to arrive at an indication of the cost of the business. Intangible assets are typically not valued under this method unless their value can be reasonably estimated. However, the cost approach can be used as a valuation method for computer software, patient records and files, and assembled workforce. See Gordon V. Smith and Russell L. Parr, Valuation of Intellectual Property and Intangible Assets, p. 232 (1989).

In the past, because of the uncertainty surrounding the sale of intangible assets created by the anti-kickback statute, the cost approach was employed by most appraisers when a hospital repurchased physicians' shares of a partnership. Normally, the hospital assumed the debt portion of its partners' obligation and purchased its partners' portion of equity in the partnership. Both parties to the transaction received appropriate value. The physicians were relieved of their debt in the partnership and received payment for their portion of the equity.

(2) The Income Approach

The Service allowed, in connection with IDS applications for exemption, the use of the income approach in the valuation of large, well established medical groups comprising a hospital and diagnostic center. The income approach allows the sale of tangible as well as certain intangible assets of the medical group. Because of these IDS cases, current valuations of partnership assets use the income approach, which employs the DCF method and places a substantial value on intangible assets. This method creates a potential problem because intangibles are difficult to measure in terms of real value and are likely to inflate the valuation.

At a minimum, any valuation of a partnership employing an income approach valuation (such as the DCF method) must use an after-tax cash flow rather than a pre-tax cash flow assumption. This adjustment in the valuation analysis will result in a significantly lower revised BEV. Comparison of Exhibits A, B, and C demonstrates how an after-tax cash flow analysis can significantly reduce the BEV of a medical practice.

However, mere use of an after-tax cash flow analysis is not enough to demonstrate FMV. The income approach focuses on incorporating the specific operating characteristics of a partnership's business into a cash flow analysis. In the analysis, cash flow that could potentially be taken out of the company without impairing operations and profitability is estimated. In most, if not all partnerships, the new OBRA provisions will substantially reduce profits once they take effect. Depending upon the number of referrals made by physician-partners, the partnership may face either diminished profits, no profits, varying degrees of losses, or even bankruptcy.

The cash flow analysis should include in the adjusted gross revenue projections reduced gross receipts resulting from OBRA. Many valuations the Service receives in connection with these ruling requests do not reflect the impact of OBRA. This results in a cash flow analysis projecting a profitable and healthy business. The selling physician-partners receive an inflated price for their partnership shares. In contrast, if the purchaser was another physician-partner, the valuation would be based on a cash flow analysis reflecting OBRA, which would substantially reduce the purchase price. In light of OBRA, it seems doubtful if any substantial value can be placed on intangibles under these facts.

(3) Preferred Approach

The cost approach, which measures FMV by determining the cost to replace or reproduce an asset, less an allowance for physical deterioration or obsolescence, is generally the correct method for most valuations of partnerships. The employment of the cost approach allows the physician-partners an opportunity to be removed from a partnership that, in the future, may suffer varying degrees of losses. The physician-partners are relieved from debt incurred in the partnership and reap the rewards of the equity in the partnership.

[Note: EXHIBITS A-D are not included in this document]